2004 WL 3263479 (Miss.Cir.) (Trial Pleading)

Circuit Court of Mississippi.
Grenada County

Ethel Juanita MCCRACKEN, by and through Carol Poovey, Next Friend, for the use and benefit of Ethel Juanita McCracken, Plaintiff,

v.

MARINER HEALTH CARE, INC. f/k/a Mariner Post-Acute Network, Inc.; Mariner Health Central, Inc.; National Heritage Realty, Inc.; Mariner Health Care Management Company f/k/a LC Management Company; MHC Mid America Holding Co.; MHC Holding Co.; Boyd P. Gentry; Michael Banes; Unidentified Entities 1 through 10 and John Does 1 through 10 (as to Grenada Health & Rehabilitation Center), Defendants.

Cause No. 2004-043/CVL
August 25, 2004.

Trial by Jury Demanded

Complaint

Wilkes & McHugh, P.A., James B. McHugh, Mississippi Bar Number 100876, Christine C. Althoff, Mississippi Bar Number 101077, Hattiesburg, MS, Attorneys for Plaintiff

Plaintiff, Ethel Juanita McCracken, by and through Carol Poovey, Next Friend, for the use and benefit of Ethel Juanita McCracken, and for her causes of action against Defendants, states:

JURISDICTIONAL STATEMENT

1. Ethel Juanita McCracken was, at all times material hereto, a resident of Grenada Health & Rehabilitation Center), a skilled nursing facility located at 1966 Hill Drive, Grenada, Grenada County, Mississippi from September 2003, until present, and suffered personal injuries and damages while a resident there.

2. Separate Defendant Mariner Health Care, Inc. f/k/a Mariner Post-Acute Network, Inc. (Mariner Health Care) is a Delaware corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for Mariner Health Care is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. At all times material to this lawsuit, Defendant Mariner Health Care has done business in Mississippi and continues to do business in Mississippi. Mariner Health Care was, and remains, a corporation engaged in the custodial care of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center.

3. Separate Defendant Mariner Health Care Management Company f/k/a LC Management Company (Mariner Health Care Management) is a Delaware corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for Mariner Health Care Management is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. Mariner Health Care Management was, and remains, a corporation engaged in the custodial care

of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center.

4. Separate Defendant Mariner Health Central, Inc. (Mariner Health Central) is a Delaware corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for Mariner Health Central is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. Mariner Health Central was, and remains, a corporation engaged in the custodial care of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center.

5. Separate Defendant MHC Holding Co. (MHC Holding) is a Delaware corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for MHC Holding is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. MHC Holding was, and remains, a corporation engaged in the custodial care of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center

6. Separate Defendant MHC Mid America Holding, Co. (MHC Mid America) is a Delaware corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for MHC Mid America is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. MHC Mid America was, and remains, a corporation engaged in the custodial care of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center.

7. Separate Defendant National Heritage Realty, Inc. (National Heritage) is a Louisiana corporation with its principal place of business at One Ravinia Drive, Ste. 1500, Atlanta, GA 39346. The agent for service for National Heritage is CT Corporation System, 645 Lakeland East Drive, Ste. 101, Flowood, MS 39232. National Heritage was, and remains, a corporation engaged in the custodial care of **elderly**, helpless individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment at Grenada Health & Rehabilitation Center.

8. Separate Defendant Boyd P. Gentry (Gentry), on information and belief, was the licensee of Grenada Health & Rehabilitation Center on or about the dates relevant to this lawsuit. Separate Defendant Gentry is a resident citizen of the State of Georgia. Separate Defendant for all times material to this lawsuit conducted business in Mississippi.

9. Separate Defendant Michael Banes (Banes), on information and belief, was the administrator for Grenada Health & Rehabilitation Center on or about the dates relevant to this lawsuit and is a resident citizen of the State of Mississippi.

10. Separate Defendants John Does 1 through 10 are individuals whom Plaintiff is currently unable to identify despite diligent efforts. Said Defendants are named pursuant to Miss. R. Civ. P. 9(h), insofar as their acts and/or omissions were negligent and/or otherwise tortious with respect to the care and treatment of, or in the staffing, supervision, administration and direction of the care and treatment of, Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center. Alternatively, Defendants are liable for the negligent and/or otherwise tortious acts and/or omissions of others with respect to the care and treatment of Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center.

11. Separate Defendants Unidentified Entities 1 through 10 are entities whom Plaintiff is currently unable to identify despite diligent efforts. Defendants are named pursuant to Miss. R. Civ. P. 9(h), insofar as their acts and/or omissions were negligent and/or otherwise tortious with respect to the care and treatment of Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center. Alternatively, Defendants are liable for the negligent and/or otherwise tortious acts and/or omissions of others with respect to the care and treatment of Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center.

12. At all times material hereto, Defendants owned, operated and/or controlled Grenada Health & Rehabilitation Center. The actions of each of Grenada Health & Rehabilitation Center's servants, agents and employees as set forth herein, are imputed to Defendants.

13. Jurisdiction of this Court is proper in the Circuit Court of Grenada County in that the amount in controversy, exclusive of interest and costs, exceeds the minimum jurisdictional limits of this Court.

FACTUAL SUMMARY

14. Since September 2003, Ethel Juanita McCracken has resided at Grenada Health & Rehabilitation Center, where she remains to this day.

15. Defendants were aware of Ethel Juanita McCracken's medical condition and the care that she required when they represented that they could adequately care for her needs.

16. At all relevant times, Defendants held themselves out as being:
a. Skilled in the performance of nursing, rehabilitative and other medical support services;

b. Properly staffed, supervised, and equipped to meet the total needs of their nursing home residents;

c. Able to specifically meet the total nursing home, medical, and physical therapy needs of Ethel Juanita McCracken and other residents like her; and,

d. Licensed and complying on a continual basis with all rules, regulations, and standards established for nursing homes, nursing home licensees and nursing home administrators.

17. Defendants failed to discharge their obligations of care to Ethel Juanita McCracken. As a consequence thereof, Ethel Juanita McCracken suffered catastrophic injuries, extreme pain and suffering and mental anguish. The scope and severity of the recurrent wrongs inflicted upon Ethel Juanita McCracken while under the care of the facility accelerated the deterioration of her health and physical condition beyond that caused by the normal aging process and resulted in physical and emotional trauma, which includes, but is not limited to:
a. **Abuse** by aides;

b. Multiple falls;

c. Pressure sores;

d. Infections;

e. Disfigurement; and

f. Poor hygiene

18. All of the above identified injuries, as well as the conduct specified below, caused Ethel Juanita McCracken to lose her personal dignity, unnecessary pain, degradation, anguish, and emotional trauma.

19. The wrongs complained of herein were of a continuing nature, and occurred throughout Ethel Juanita McCracken's stay at Defendants' facility.

20. Plaintiff alleges that on all of the occasions complained of herein, Ethel Juanita McCracken was under the care, supervision, and treatment of the agents and/or employees of Defendants and that the injuries complained of herein were proximately caused by the acts and omissions of Defendants named herein.

21. Defendants had vicarious liability for the acts and omissions of all persons or entities under Defendants' control, either directly or indirectly, including their employees, agents, consultants, and independent contractors, whether in-house or outside entities, individuals, agencies, or pools causing or contributing to the injuries of Ethel Juanita McCracken.

22. Defendants have joint and several liability for the actions complained of herein because they consciously and deliberately pursued a common plan or design to commit the tortious acts described in this Complaint and these Defendants actively took part in such actions.

COUNT ONE: NEGLIGENCE AGAINST SEPARATE DEFENDANTS MARINER HEALTH CARE, MARINER HEALTH CARE MANAGEMENT, MARINER HEALTH CENTRAL, MHC MID AMERICA, MHC HOLDING, NATIONAL HERITAGE, AND UNIDENTIFIED ENTITIES 1 THROUGH 10

23. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-22 as if set forth herein.

24. Separate Defendants owed a duty to residents, including Ethel Juanita McCracken, to provide adequate and appropriate custodial care and supervision, which a reasonably careful person would provide under similar circumstances.

25. Separate Defendants owed a duty to residents, including Ethel Juanita McCracken, to exercise reasonable care in providing care and services in a safe and beneficial manner.

26. Separate Defendants breached this duty by failing to deliver care and services that a reasonably careful person would have provided under similar circumstances and by failing to prevent the mistreatment, **abuse** and neglect of Ethel Juanita McCracken.

27. The negligence of Separate Defendants their employees, agents and consultants, includes, but is not limited to, the following acts and omissions:
a. The failure to provide Ethel Juanita McCracken with adequate and appropriate hygiene care, including the failure to bathe her daily after each incontinent episode so as to prevent urine and fecal contact with her skin for an extended period of time;

b. The failure to provide and ensure that Ethel Juanita McCracken received adequate hygiene and sanitary care to prevent infection;

c. The failure to protect Ethel Juanita McCracken from falls and fall-like events;

d. The failure to provide adequate turning and repositioning of Ethel Juanita McCracken in order to provide pressure relief so as to prevent the formation of pressure sores on her body;

e. The failure to provide the minimum number of staff necessary to assist the residents, including Ethel Juanita McCracken, with their needs;

f. The failure to provide proper custodial care, and wound care and to prescribe and administer proper medication to prevent Ethel Juanita McCracken's existing medical conditions to worsen to the point of becoming life-threatening;

g. The failure to maintain appropriate records, including the obvious failure to monitor and document significant changes in Ethel Juanita McCracken's condition;

h. The failure to provide sufficient numbers of qualified nursing personnel to meet the total needs of Ethel Juanita McCracken;

i. The failure to protect Ethel Juanita McCracken from **abuse** and neglect;

j. The failure to increase the number of nursing personnel to ensure that Ethel Juanita McCracken:

1. Received timely and accurate care assessments;

2. Received prescribed treatment, medication, and diet;

3. Received necessary supervision; and

4. Received timely nursing and medical intervention due to a significant change in condition.

k. The failure to provide nursing personnel sufficient in number to ensure that Ethel Juanita McCracken attained and maintained her highest practicable level of physical, mental and psychosocial well-being;

l. The failure to provide adequate supervision to the nursing staff so as to ensure that Ethel Juanita McCracken received adequate and proper nutrition, fluids, therapeutic diet, sanitary care treatments and medications, and sufficient nursing observation and examination of the responses, symptoms, and progress in the physical condition of Ethel Juanita McCracken;

m. The failure to adequately assess, evaluate, and supervise nursing personnel so as to ensure that Ethel Juanita McCracken received appropriate nursing care, in accordance with Defendants' policies and procedures, and the statutorily mandated regulations implemented by the Mississippi Department of Health and its agents, including the Office of Licensing and Certification;

n. The failure to provide a nursing staff that was properly staffed, qualified, and trained;

o. The failure to adopt adequate guidelines; policies and procedures for documenting; maintaining files; investigating and responding to any complaint regarding the quality of resident care or misconduct by employees - irrespective of whether such complaint derived from a state survey agency, a resident of the facility, an employee of the facility or any interested person

p. The failure to take reasonable steps to prevent, eliminate, and correct deficiencies and problems in resident care;

q. The failure to provide care, treatment, and medication in accordance with physician's orders;

r. The failure to provide a safe environment;

s. The failure to maintain medical records on Ethel Juanita McCracken in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized with respect to:

1. The diagnosis of Ethel Juanita McCracken;

2. The treatment of Ethel Juanita McCracken; and

3. The assessment and establishment of appropriate care plans of care and treatment; and

t. The failure to protect Ethel Juanita McCracken from harm within the facility;

28. A reasonably careful nursing home operating under similar circumstances would foresee that the failure to provide the ordinary care listed above would result in devastating injuries to Ethel Juanita McCracken.

29. As a direct and proximate result of the negligence of Separate Defendants as set out above, Ethel Juanita McCracken suffered injuries, as set forth herein all of which required hospitalization and medical treatment, and all of which required Ms. McCracken to incur significant hospital and medical expenses.

30. WHEREFORE, based on such conduct of Separate Defendants as set forth above, Plaintiff asserts a claim for judgment for compensatory and punitive damages against Separate Defendants including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, humiliation, disfigurement and death in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT TWO: NEGLIGENCE CLAIM AGAINST SEPARATE DEFENDANT GENTRY

31. Plaintiff hereby re-alleges and incorporates the allegations in paragraphs 1-30 as if fully set forth herein.

32. Separate Defendant Gentry was the licensee of Grenada Health & Rehabilitation Center during the residency of Ethel Juanita McCracken. By becoming licensee, Separate Defendant willingly and voluntarily assumed the ultimate responsibility to operate Grenada Health & Rehabilitation Center in a manner that would ensure that each resident, including Ethel Juanita McCracken, met her highest practicable physical, mental and psychosocial well-being.

33. As licensee of Grenada Health & Rehabilitation Center, Separate Defendant was responsible to ensure that the operation of the facility was in compliance with state and federal statutes and regulations.

34. As licensee of Grenada Health & Rehabilitation Center, Separate Defendant had a non-delegable duty to ensure that the residents of Grenada Health & Rehabilitation Center including Ethel Juanita McCracken, received adequate and appropriate care that a reasonable person would provide under similar circumstances.

35. As licensee of Grenada Health & Rehabilitation Center, Separate Defendant was required to be aware of matters occurring at the nursing home and to take affirmative steps to correct problems, particularly when those problems could reasonably cause or contribute to an injury to a resident of the facility.

36. As licensee of Grenada Health & Rehabilitation Center, Separate Defendant is vicariously liable for the acts and omissions of all persons or entities under their control.

37. Separate Defendant failed to supervise Grenada Health & Rehabilitation Center in the manner in which a reasonably prudent person similarly situated would and failed to take steps to ensure that the residents of Grenada Health & Rehabilitation Center, including Ms. McCracken, were receiving adequate and appropriate care. The negligence of Separate Defendant includes, but is not limited to one or more of the following acts and omissions:
a. The failure to timely and adequately review records related to the operation of Grenada Health & Rehabilitation Center in order to ensure that the residents, including Ethel Juanita McCracken, received adequate and appropriate care.

b. The failure to ensure that the facility had sufficient numbers of qualified nursing personnel. Such failures resulted in injuries to Ethel Juanita McCracken, and include but are not limited to the following:

1. The failure to provide Ethel Juanita McCracken with adequate care and supervision in order to prevent falls and fall-like events;

2. The failure to provide Ethel Juanita McCracken with necessary and adequate continence care and assistance with toileting;

3. The failure to provide Ethel Juanita McCracken with adequate and appropriate hygiene care, including the failure to bathe her daily after each incontinent episode so as to prevent urine and fecal contact with her skin for an extended period of time, thereby preventing pressure sores from developing and progressing;

4. The failure to provide and ensure that Ethel Juanita McCracken received adequate hygiene and sanitary care to prevent pressure sores from developing and progressing;

5. The failure to provide clean bed linens to Ethel Juanita McCracken as needed to prevent urine and fecal contact for an extended period of time,

6. The failure to provide adequate turning and repositioning of Ethel Juanita McCracken in order to provide pressure relief so as to prevent the formation of pressure sores on her body;

7. The failure to provide the minimum number of staff necessary to assist the residents with their needs;

8. The failure to maintain appropriate records, including the failure to monitor and document significant changes in Ethel Juanita McCracken's condition;

9. The failure to protect Ethel Juanita McCracken from **abuse** and neglect;

10. The failure to provide sufficient numbers of qualified personnel, including nurses, licensed practical nurses, certified nurse assistants, and medication aides (nursing personnel) to meet the total needs of Ethel Juanita McCracken;

11. The failure to increase the number of personnel to ensure that Ethel Juanita McCracken:

I. Received timely and accurate care assessments;

II. Received prescribed treatment, medication, and diet;

III. Received necessary supervision; and

IV. Received timely intervention due to a significant change in condition.

12. The failure to provide nursing personnel sufficient in number to ensure that Ethel Juanita McCracken attained and maintained her highest level of physical, mental and psychosocial well-being;

13. The failure to provide adequate supervision to the nursing staff so as to ensure that Ethel Juanita McCracken received adequate and proper nutrition, fluids, therapeutic diet, sanitary care treatments and medications, and sufficient nursing observation and examination of the responses, symptoms, and progress in the physical condition of Ms. McCracken;

14. The failure to adequately assess, evaluate and supervise nursing personnel so as to ensure that Ethel Juanita McCracken received appropriate nursing care, in accordance with Defendants' policy and procedures manual, and the statutorily mandated regulations implemented by the Mississippi Department of Health and its agents, including the Division of Health Facilities Licensure and Certification;

15. The failure to provide a nursing staff that was properly staffed, qualified, and trained;

16. The failure to provide and ensure an adequate nursing care plan based on the needs of Ethel Juanita McCracken;

17. The failure to provide and ensure adequate nursing care plan revisions and modifications as the needs of Ethel Juanita McCracken changed;

18. The failure to adopt adequate guidelines; policies and procedures for documenting; maintaining files; investigating and responding to any complaint regarding the quality of resident care or misconduct by employees - irrespective of whether such complaint derived from a state survey agency, a resident of the facility, an employee of the facility or any interested person;

19. The failure to take reasonable steps to prevent, eliminate, and correct deficiencies and problems in resident care;

20. The failure to properly and timely notify Ethel Juanita McCracken's attending physician significant changes in Ms. McCracken's physical condition, specifically: **abuse** by aides, falls, pressure sores, infections, poor hygiene, disfigurement and persistent, unresolved problems relating to the care and physical condition of Ethel Juanita McCracken resulting in her unnecessary pain, agony, and suffering;

21. The failure to provide a safe environment;

22. The failure to maintain medical records on Ethel Juanita McCracken in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized with respect to:

I. The diagnosis of Ethel Juanita McCracken;

II. The treatment of Ethel Juanita McCracken; and

III. The assessment and establishment of appropriate care plans of care and treatment.

23. The failure to provide Ethel Juanita McCracken with adequate and appropriate wound care, including timely dressing changes, so as to prevent the aggravation and deterioration of pressure sores on her body; and

24. The failure to provide Ethel Juanita McCracken with adequate and appropriate observation and examination for skin breakdown so as to timely and adequately intervene to prevent the formation of pressure sores on her body.

38. A reasonably careful nursing home licensee, operating under similar circumstances, would foresee that the failure to provide the ordinary care listed above would result in devastating injuries to Ethel Juanita McCracken.

39. As a direct and proximate result of the negligence of Separate Defendant as set forth above, Ethel Juanita McCracken suffered injuries as set forth herein.

40. WHEREFORE, based on the conduct of Separate Defendants as set forth above, Plaintiff asserts a claim for judgment for compensatory and punitive damages against Separate Defendant including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, humiliation, disfigurement and death in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT THREE: NEGLIGENCE CLAIM AGAINST SEPARATE DEFENDANTS BANES AND JOHN DOES 1 THROUGH 10

41. Plaintiff incorporates the allegations in paragraphs 1-40 as if set forth herein.

42. Upon information and belief, Separate Defendants Banes and John Does 1 through 10 were the administrators of Grenada Health & Rehabilitation Center during the residency of Ethel Juanita McCracken. To the extent the names of the licensed administrators who may have managed this facility during the residency of Ms. McCracken are determined, all of the following acts are properly attributed to them and Plaintiff will seek leave to substitute these individuals as proper party Defendants.

43. As nursing home administrators, Separate Defendants owed a common law duty to act as reasonably prudent nursing home administrators and to prevent all reasonably foreseeable injuries to the residents of Grenada Health & Rehabilitation Center.

44. As nursing home administrators, Separate Defendants owed a common law duty to remain informed as to events occurring at Grenada Health & Rehabilitation Center through contact with the various departments that they managed, including, but not limited to, nursing, dietary, therapy, housekeeping, social services, and maintenance. Separate Defendants were required under law to be aware of matters occurring at the nursing home and to take affirmative steps to correct problems, particularly when those problems could reasonably cause or contribute to an injury, **abuse** or neglect to residents of the home.

45. When Separate Defendants accepted the position of administrator of Grenada Health & Rehabilitation Center they assumed the duties as set forth in the preceding paragraphs.

46. It is reasonably foreseeable that injuries, **abuse** and neglect to residents of Grenada Health & Rehabilitation Center, including Ethel Juanita McCracken, would occur as a direct result of Separate Defendants' failures to carry out their duties as administrators of the facility.

47. As nursing home administrators, Separate Defendants were centrally involved and actively participated in tortious conduct that directly caused or contributed to the injuries of Ethel Juanita McCracken The following areas describe with specificity the wrongdoings of Separate Defendants that resulted in harm to Ms. McCracken:
a. Staffing

1. Nursing home residents, including Ethel Juanita McCracken, often are unable to care for themselves; thus, they rely on nursing home staff to provide many, if not all, of their activities of daily living (ADL's). Nursing facilities have a common law duty, as well as a statutory duty, to have sufficient nursing staff to provide for the needs of their residents.

2. The administrator is responsible and required to hire and maintain sufficient staff to ensure that these residents' needs are met. Further, the administrator must establish and maintain proper working relationships with physicians, nurse practitioners, and employees of the facility.

3. When the administrator, as here, fails to hire and maintain sufficient staff and fails to maintain proper working relationships between the departments of the facility, the residents do not receive adequate and appropriate care.

4. Additionally, when the administrator fails to hire and maintain sufficient staff, the staff who are present are unable to meet the total needs of the residents through no fault of their own.

5. When the administrator fails to hire and maintain sufficient staff, those who are present must take shortcuts with respect to the care provided and are unable to provide adequate and appropriate care to the residents of the facility.

6. Rather than hiring and maintaining sufficient staff Separate Defendants hired too few registered nurses, too few LPNs, and too few certified nurse assistants. More importantly, too many of these staff members skipped work or terminated their employment because they did not have enough co-workers to properly care for the residents who depended upon them, or because of deplorable working conditions, or because the pay set by the nursing home with the input of the administrator was too low, or such other reasons as will be proven at trial of this matter.

7. Separate Defendants failed to develop and maintain proper working relationships between physicians, nurse practitioners and employees of the facility, and between the various departments they managed. Ethel Juanita McCracken was injured through their failure to manage these individuals and departments in a way that they could fluidly and seamlessly work together.

8. Due to staff shortages at Grenada Health & Rehabilitation Center Ethel Juanita McCracken's medical records were not kept and maintained in accordance with accepted professional standards and practices. This incomplete documentation resulted in further injuries to Ms. McCracken - the facility was unable to properly understand her condition, changes that occurred in her condition, and whether or not her care plan and dietary assessments were properly modified to address changes in her condition.

9. Separate Defendants owed a non-delegable duty to Ethel Juanita McCracken and other residents of Grenada Health & Rehabilitation Center, during their tenure as administrators, to ensure adequate and appropriate custodial care and supervision through their control over staffing issues. A reasonably prudent nursing home administrator would have known or should have known that injuries would occur to residents such as Ethel Juanita McCracken if staffing levels were not maintained within reasonable parameters.

10. With respect to staffing, the failures of Separate Defendants include but are not limited to:

I. Ensuring that the staff provided Ethel Juanita McCracken adequate hygiene and sanitary care;

II. Ensuring that the staff provided Ethel Juanita McCracken clean bed linens to prevent urine and fecal contact for extended periods of time;

III. Ensuring that Ethel Juanita McCracken received adequate care and supervision in order to prevent falls and fall-like events;

IV. Providing sufficient numbers of qualified personnel, including nurses, licensed practical nurses, certified nurse assistants, and medication aides (nursing personnel) to meet the total needs of Ethel Juanita McCracken throughout her residency;

V. Ensuring that Ethel Juanita McCracken:

a. Received timely and accurate care assessments;

b. Received prescribed treatment, medication and diet; and

c. Was protected from accidental or intentional injuries by the correct use of ordered and reasonable safety measures and proper supervision of staff and other residents;

VI. Keeping Ethel Juanita McCracken clean and comfortable and to prevent the formation of bedsores, ulcers and lesions on her body;

VII. Providing a safe environment free from preventable **abuse** and neglect;

VIII. Ensuring that Ethel Juanita McCracken received care, treatment and medication in accordance with physician's orders;

IX. Ensuring that Ethel Juanita McCracken was provided with the dignity and respect that all nursing home residents are entitled to receive;

X. Providing adequate supervision to the nursing staff to ensure that Ethel Juanita McCracken received adequate and proper sanitary care, medications, repositioning, turning and skin care to prevent the formation of bedsores, ulcers and lesions;

XI. Adequately screen, evaluate and check references, test for competence, and use ordinary care in selecting nursing personnel to work at Grenada Health & Rehabilitation Center;

XII. Terminating employees at Grenada Health & Rehabilitation Center assigned to Ethel Juanita McCracken that were known (or should have been known) to be careless, incompetent and unwilling to comply with the policy and procedures of the facility and the rules and regulations promulgated and adopted by the Mississippi Department of Health;

XIII. Assigning nursing personnel at Grenada Health & Rehabilitation Center consistent with their education and experience and based on:

a. Ethel Juanita McCracken's medical history and condition, nursing and rehabilitative needs;

b. The characteristics of the resident population residing in the area of the facility where Ethel Juanita McCracken was a resident; and

c. Nursing skills needed to provide care to such resident population.

11. Separate Defendants failed to implement adequate guidelines, policies and procedures for:

I. Investigating the relevant facts, underlying deficiencies, or licensure violations or penalties found to exist at Grenada Health & Rehabilitation Center by the Mississippi Department of Health or any state or federal survey agency;

II. Determining the cause of any such deficiencies, violations or penalties; and

III. Correcting deficiencies or licensure violations or penalties found to exist at Grenada Health & Rehabilitation Center.

12. Adopting adequate guidelines, policies, and procedures for determining whether Grenada Health & Rehabilitation Center had sufficient numbers of nursing personnel to:

I. Provide 24-hour nursing services;

II. Meet the needs of residents who reside at the facility, including Ethel Juanita McCracken; and

III. Meet the total nursing needs of residents, including their activities of daily living.

13. Separate Defendants failed to adopt adequate guidelines, polices, and procedures of Grenada Health & Rehabilitation Center for documenting; maintaining files; investigating and responding to any complaint regarding the quality of resident care or misconduct by employees at Grenada Health & Rehabilitation Center regardless of whether such complaint derived from a state survey agency, a resident of the facility, an employee of the facility or any interested person. This failure resulted in injury, **abuse** and neglect to residents of the facility, including Ethel Juanita McCracken.

14. Separate Defendants failed to take reasonable steps to prevent, eliminate, and correct deficiencies and problems in resident care at Grenada Health & Rehabilitation Center.

15. Separate Defendants failed to ensure that Ethel Juanita McCracken attained and maintained her highest level of physical, mental and psychosocial well-being, and the breach of other of their non-delegable duties regarding staffing directly caused damages to Ethel Juanita McCracken.

b. Budgeting or Allocation of Resources

1. As administrators, Separate Defendants were responsible for providing accurate information regarding the monetary needs of the facility to the owners of the nursing home so that a workable budget could be set.

2. As administrators, Separate Defendants were required to administer Grenada Health & Rehabilitation Center in a manner that enabled it to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

3. As administrators, Separate Defendants were responsible for allocating funds within the budget provided them by the owners of the nursing home in a manner that ensured that the needs of the residents, including Ethel Juanita McCracken, were met.

4. Separate Defendants failed to properly report the budgetary needs of the facility and to properly allocate the funds budgeted to the facility for the proper care of its residents, resulting in the following:

I. Staffing levels that were insufficient to attain or maintain the highest practicable physical, mental and psychosocial well-being of each residents, including Ethel Juanita McCracken, and

II. Shortages of supplies and food necessary to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, including Ethel Juanita McCracken.

5. Upon information and belief, Plaintiff alleges that rather than properly allocating the budgeted funds, Separate Defendants inappropriately allocated or allowed funds to be paid to management companies that did not assist or even participate in managing the care provided to the residents. Rather, Separate Defendants only enhanced the profits of the home, allocated funds to employees whose only duties were non-patient oriented and to items and services that were unnecessary to achieve the proper goal of providing adequate and appropriate care to the residents.

6. The failure to adequately budget and allocate resources to the facility directly caused damages to Ethel Juanita McCracken.

c. Corporate Compliance and Reporting

1. As administrators of Grenada Health & Rehabilitation Center, Separate Defendants were responsible for ensuring that the facility complied with state and federal standards in providing care to the residents of the home. To that end, they were required to file various reports with regulatory entities.

2. As administrators, Separate Defendants were charged with the responsibility of reporting instances of **abuse** and neglect that occurred at the facility. Upon information and belief, Plaintiff alleges that their failure to properly and timely do so resulted in additional injuries to residents, including Ethel Juanita McCracken.

3. Upon information and belief, Plaintiff alleges that Separate Defendants failed to properly recognize and report instances of non-compliance occurring at Grenada Health & Rehabilitation Center, and further failed to correct those instances. These failures to report resulted in the appearance of a facility that was properly managed and maintained. This false and misleading appearance induced the family of Ethel Juanita McCracken to place her in the facility and misled them as to the care she would receive at the facility. Further, upon information and belief, Plaintiff alleges that because certain problems were not reported or

were underreported, the facility escaped inspections and investigations by regulatory agencies and even in-house reviews that might have corrected the deficiencies. These deficiencies that the facility experienced created a more dangerous environment in which additional injuries could occur to residents, including Ethel Juanita McCracken.

4. Separate Defendants were responsible for ensuring that no claims for reimbursement were submitted to the federal or state governments for services that were not provided or services provided that failed to meet required standards. Upon information and belief, Separate Defendants submitted false claims as a result of the various staffing issues listed above, resulting in unjust enrichment to the facility and a breach of Ethel Juanita McCracken's admissions agreement.

5. The failure to adequately comply with and report violations of state and federal standards directly caused harm to Ethel Juanita McCracken.

48. A reasonably careful nursing home administrator would have foreseen that the failure to provide the ordinary care listed above would result in devastating injuries to Ethel Juanita McCracken.

49. WHEREFORE, based on such conduct of Separate Defendants as set forth above, Plaintiff asserts a claim for judgment for compensatory and punitive damages against Separate Defendants including, but not limited to, medical expenses, pain and suffering, mental anguish, disability, humiliation and disfigurement in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT FOUR: MEDICAL MALPRACTICE AGAINST MARINER HEALTH CARE, MARINER HEALTH CARE MANAGEMENT, MARINER HEALTH CENTRAL, MHC MID AMERICA, MHC HOLDING, AND NATIONAL HERITAGE

50. Plaintiff hereby re-alleges and incorporates the allegations in paragraphs 1-49 as if fully set forth herein.

51. Separate Defendants owed a duty to residents, including Ethel Juanita McCracken, to hire, train, and supervise employees so that such employees delivered care and services to residents in a safe and beneficial manner.

52. Separate Defendants owed a duty to residents, including Ethel Juanita McCracken, to render care and services as a reasonably prudent and similarly situated nursing home employee would render, including, but not limited to, rendering care and services in a safe and beneficial manner.

53. Separate owed a duty to assist all residents, including Ethel Juanita McCracken, in attaining and maintaining the highest level of physical, mental, and psychosocial well-being.

54. Separate Defendants failed to meet the standard of care and violated their duty of care to Ethel Juanita McCracken through mistreatment, **abuse** and neglect. The medical negligence of these Defendants, their employees, and their consultants, includes, but is not limited to, the following acts and omissions:
a. The failure to provide and ensure that Ethel Juanita McCracken received adequate hygiene and sanitary care to prevent infection;

b. The failure to properly assess Ethel Juanita for the risk of falls;

c. The failure to provide proper custodial care, and wound care and to prescribe and administer proper medication to prevent Ethel Juanita McCracken's existing medical conditions to worsen to the point of becoming life-threatening;

d. The failure to properly assess Ethel Juanita McCracken for the risk of development of pressure sores;

e. The failure to develop, implement, and update an adequate and appropriate resident care plan to meet the needs of Ethel Juanita McCracken;

f. The failure to maintain appropriate records, including the failure to monitor and document significant changes in Ethel Juanita McCracken's condition;

g. The failure to provide and ensure an adequate nursing care plan based on the needs of Ethel Juanita McCracken;

h. The failure to provide and ensure adequate nursing care plan revisions and modifications as the needs of Ethel Juanita McCracken changed;

i. The failure to implement and ensure that an adequate nursing care plan for Ethel Juanita McCracken was followed by nursing personnel;

j. The failure to take reasonable steps to prevent, eliminate, and correct deficiencies and problems in resident care;

k. The failure to provide Ethel Juanita McCracken with adequate and appropriate observation and examination following an injury so as to timely and adequately provide appropriate emergency medical care;

l. The failure to provide care, treatment, and medication in accordance with physician's orders;

m. The failure to properly and timely notify Ethel Juanita McCracken's attending physician of significant changes in her physical condition, including, but not limited to, **abuse** by aides, falls, pressure sores, infections, poor hygiene and disfigurement;

n. The failure to adequately and appropriately monitor Ethel Juanita McCracken and recognize significant changes in her health status; and

o. The failure to respond to significant signs and symptoms of change in the condition of Ethel Juanita McCracken.

55. A reasonably prudent nursing home operating under the same or similar conditions, would not have failed to provide the care listed in the above paragraph. Each of the foregoing acts of medical negligence on the part of Separate Defendants was a proximate cause of Ethel Juanita McCracken's injuries. Ethel Juanita McCracken's injuries were foreseeable to these Defendants.

56. Separate Defendants' conduct in breaching the duties owed to Ethel Juanita McCracken was grossly negligent, willful, wanton, malicious and reckless.

57. As a direct and proximate result of such grossly negligent, willful, wanton, reckless and malicious conduct, Ethel Juanita McCracken suffered injuries and also suffered extreme pain, suffering, and mental anguish, all of which required medical treatment. As a result, Ms. McCracken incurred significant medical expenses.

58. WHEREFORE, based on the conduct set forth above of Separate Defendants, Plaintiff asserts a claim for judgment for compensatory and punitive damages against these Defendants including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, humiliation and disfigurement in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT FIVE: MALICE, AND/OR GROSS NEGLIGENCE WHICH EVIDENCES A WILLFUL, WANTON, OR RECKLESS DISREGARD FOR THE SAFETY OF ETHEL JUANITA MCCRACKEN AGAINST ALL DEFENDANTS

59. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-58 as if fully set forth herein.

60. The longevity, scope and severity of the Defendants' failures and actions constitute malice, and/or gross negligence that evidences a willful, wanton or reckless disregard for the safety of others, including Ethel Juanita McCracken. Specifically, such conduct was undertaken by Defendants without regard to the health and safety consequences to those residents, such as Ethel Juanita McCracken, entrusted to their care. Moreover, such conduct evidences little regard for their duties of care, good faith, and fidelity owed to Ms. McCracken.

61. The malice, and/or gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, including Ethel Juanita McCracken, includes, but is not limited to, acts and omissions as alleged in Paragraph 27, 37, 47 and 54.

62. As a direct and proximate result of the above cited malice, and/or gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, including Ethel Juanita McCracken, she suffered injuries as set forth herein, all of which required Ms. McCracken to incur significant medical expenses.

63. WHEREFORE, based on such conduct of Defendants, Plaintiff asserts a claim for judgment for compensatory and punitive damages against Defendants including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, and humiliation, and disfigurement in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT SIX: FRAUD AGAINST ALL DEFENDANTS

64. Plaintiff re-alleges and incorporates the allegations in paragraph 1-63 as if fully set forth herein.

65. Defendants intentionally engaged in common law fraud, which was a proximate cause of the injuries and damages described herein. Defendants, while claiming or implying special knowledge, concealed and/or misrepresented material facts to Ethel Juanita McCracken and her family beginning with her admission in September 2003, and continuing throughout Ms. McCracken's residency at Grenada Health & Rehabilitation Center. Defendants either personally, or through their agents or employees, specifically misrepresented that they could and would provide twenty-four hour a day nursing care and supervision to Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center.

66. Defendants made these misrepresentations with the knowledge that they would not and/or could not provide twenty-four hour a day nursing care and supervision to Ethel Juanita McCracken during her residency at Grenada Health & Rehabilitation Center because they were not sufficiently staffed or supplied.

67. The relationship between Defendants and Ethel Juanita McCracken and her family was one of trust and confidence, thereby imparting upon Defendants a higher duty to affirmatively speak the truth and to disclose adverse facts to Ethel Juanita McCracken and her family because of Ms. McCracken's age and infirmities and the surrounding circumstances. Defendants' fraudulent conduct includes, but is not limited to, the conduct described above and set forth below.

68. Defendants knowingly concealed or failed to disclose material facts, even though Defendants knew or reasonably should have known, that because of the surrounding circumstances that Ethel Juanita McCracken and her family were ignorant of these material facts and did not have an equal opportunity to discover the truth. Specifically, Defendants either personally or through their agents or employees misrepresented the material facts either by omission or affirmative statements that they were willing to, and would, provide the proper care, treatment and services to Ethel Juanita McCracken, even though Defendants

knew that they would provide as little care, treatment and services as possible in order to maximize Defendants' profits at the expense of Ms. McCracken.

69. Further, Defendants made the misrepresentations with the intent to induce Ethel Juanita McCracken and her family to take some action: specifically, to admit and not remove Ms. McCracken from Defendants' facility, by concealing or failing to disclose the material facts that there was an epidemic of resident harm and injury, as well as a practice of utilizing insufficient numbers of nursing aides who were not qualified to render care or services in accordance with the law during Ms. McCracken's residency. As a proximate cause of Defendants' concealment and failure to disclose, these adverse material facts, Ethel Juanita McCracken suffered injuries as set forth herein.

70. Ethel Juanita McCracken and her family detrimentally relied on Defendants' misrepresentations.

71. Defendants' material misrepresentations beginning in September 2003, and continuing through present were made with knowledge of their falsity and with the intention that such misrepresentations should be relied upon by Ethel Juanita McCracken and her family to Ms. McCracken's detriment. As a consequence and proximate cause of the reasonable and detrimental reliance by Ethel Juanita McCracken and her family on these misrepresentations of commission and omission, Ms. McCracken and her family suffered injury.

72. As a result of Defendants' misrepresentation, Defendants obtained an agreement with, or on behalf of, Ethel Juanita McCracken and/or her family, in September 2003, wherein Defendants promised to provide basic care for Ms. McCracken. As partial consideration for this promise, Ethel Juanita McCracken and/or her family agreed to turn over virtually all of her income to these Defendants on a monthly basis. At the time of this agreement, it was known and understood by all parties that Defendants, for good and sufficient consideration, had also entered into agreements with the State of Mississippi and other relevant licensing and regulatory authorities that were designed and intended to be for the benefit and protection of Ethel Juanita McCracken and others who were similarly situated. By virtue of these agreements and by direct statement beginning in September 2003, and continuing until present, Defendants either personally or through their agents or employees represented to Ethel Juanita McCracken and her family that the care Defendants would provide for Ms. McCracken would fully comply with the licensing requirements and standards of care specified by the laws and regulations of the State of Mississippi and other relevant licensing and regulatory authorities.

73. At all times relevant to this proceeding, Defendants held themselves out to Plaintiff and the public at large to be a nursing home licensed by the State of Mississippi and certified to provide care to nursing home residents. At all times material to this lawsuit, the aforesaid agreements, obligations and promises, which were a part thereof, were renewed on a monthly basis by virtue of payment made by, or on behalf of, Ethel Juanita McCracken, to Defendants for care to be rendered for the upcoming month. Defendants were paid each month in advance of care to be provided pursuant to the admission agreement and promises which were a part thereof, including but not limited to the resident's bill of rights.

74. WHEREFORE, based on such conduct of all of the Defendants as set out above, Plaintiff asserts a claim for judgment for compensatory and punitive damages against all Defendants including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, humiliation, and disfigurement in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT SEVEN: BREACH OF FIDUCIARY DUTY AGAINST ALL DEFENDANTS

75. Plaintiff re-alleges and incorporates the allegations in paragraph 1-74 as if fully set forth herein.

76. Because of her mental and physical infirmities, Ethel Juanita McCracken was particularly dependent upon Defendants, their employees and agents for her daily care and well-being. Because of the nature of this dependency, the representations of Defendants that they could and would provide necessary care and the dominant influence Defendants exhorted over Ethel

Juanita McCracken on a daily basis while she resided at Grenada Health & Rehabilitation Center, Ms. McCracken and her family held in all Defendants a special confidence and trust. Defendants accepted this special confidence and trust by admitting Ethel Juanita McCracken to their facility and by determining the level of care to be provided to Ms. McCracken.

77. Ethel Juanita McCracken and her family relied upon Defendants' superior knowledge, skill, and abilities, which they held themselves out to possess. Ethel Juanita McCracken and her family also relied on the Defendants to provide care for Ethel Juanita McCracken who, because of her age and infirmities, was not able to care for herself.

78. By virtue of the nature of the services Defendants provided to Ethel Juanita McCracken, the special relationship that existed between Defendants and Ms. McCracken, the exhortion of influence Defendants had over Ms. McCracken, the huge disparity of power and unequal bargaining position existing between Defendants and Ms. McCracken, as well as all of the other surrounding circumstances including but not limited to Ethel Juanita McCracken's mental and physical infirmities, Defendants occupied a position of trust and confidence toward Ms. McCracken that required among other things fidelity, loyalty, good faith, and fair dealing by the Defendants.

79. By accepting payment for services and care that was not provided to Ethel Juanita McCracken, and concealing and failing to disclose their **abuse** and neglect of Ms. McCracken, Defendants breached their confidential and fiduciary duties, namely, the duties of good faith and fair dealing, to Ms. McCracken by failing to provide the appropriate level of care and services to which she was entitled.

80. As a proximate cause of the foregoing breaches of duty by all of the Defendants, Ethel Juanita McCracken suffered injuries as set forth herein.

81. WHEREFORE, based on such conduct of all of the Defendants as set out above, Plaintiff asserts a claim for judgment for compensatory and punitive damages against all Defendants including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, humiliation, disfigurement and death in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law. Plaintiff also seeks the imposition of a constructive trust on all wrongful profits and proceeds arising out of Defendants' breach of fiduciary duty to Ethel Juanita McCracken.

PRAYER FOR RELIEF

Pursuant to the Mississippi Rules of Civil Procedure, Plaintiff demands that all issues of fact in this case be tried to a jury.

WHEREFORE, Ethel Juanita McCracken, by and through Carol Poovey, Next Friend, for the use and benefit of Ethel Juanita McCracken, and for her causes of action, prays for judgment against all Defendants, as follows:
1. For damages to be determined by the jury, in an amount exceeding the minimum jurisdictional amount of this Court, and adequate to compensate Plaintiff for all the injuries and damage sustained;

2. For all general and special damages caused by the alleged conduct of Defendants;

3. For the costs of litigating this case;

4. For punitive damages sufficient to punish Defendants for their egregious conduct and to deter all Defendants from repeating such atrocities; and

5. For all other relief to which Plaintiff is entitled by Mississippi law.

Respectfully submitted,

Ethel Juanita McCracken, by and through Carol Poovey, Next Friend, for the use and benefit of Ethel Juanita McCracken

WILKES & McHUGH, P.A.

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